Before the
Administrative Hearing Commission
State of Missouri

JAMES DYE, D.D.S., BRENDA HERRMAN, D.D.S., and ALL ABOUT SMILES, L.L.C.,	)	
Petitioners,	)	
vs.	)	No. 13-2108 SP
DEPARTMENT OF SOCIAL SERVICES, MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT,	)	
Respondent.	)	

DECISION

The Department of Social Services, Missouri Medicaid Audit and Compliance Unit ("MMAC") denied 35 reimbursement claims for dentures submitted by Petitioners James Dye, D.D.S. and Brenda Herman, D.D.S. ("the dentists") through All About Smiles, L.L.C., ("All About Smiles"), their billing agent. We determine that eight of the claims are eligible for complete or partial reimbursement and the remaining 27 are not. Petitioners are entitled to reimbursement of $6,799.86.

Procedure

All About Smiles and the dentists (together, "the Petitioners")[1] filed a complaint on December 10, 2013, appealing MMAC's decision to deny payment for denture claims submitted by the Petitioners. MMAC filed an answer on January 13, 2014.

[1] It is unclear whether All About Smiles has standing to pursue these claims. In a case involving the same parties in the Cole County Circuit Court, MMAC requested and the court granted dismissal of All About Smiles' petition because it did not "allege facts establishing that it has been aggrieved by an action of MMAC in such a manner as to afford it standing to seek judicial review pursuant to RSMo. § 536.150." All of Petitioners' filings have included All About Smiles as a listed party in the caption; all of MMAC's filings have omitted All About Smiles from the caption. However, unlike the proceeding in circuit court, MMAC has not moved to dismiss All About Smiles from this case. Therefore, we have not changed the caption of the case or dismissed All About Smiles as a party.

We held a hearing on this matter on April 15, 2014. James Arneson represented the Petitioners. Assistant Attorney General Matthew J. Laudano represented MMAC. The case became ready for our decision on June 24, 2014, the date the last written argument was filed.

Findings of Fact

1. The dentists are, and were at all relevant times, enrolled in the Missouri Medicaid dental services program. All About Smiles supplies staff for them and acts as their billing agent.

2. As Medicaid dental services providers, the dentists entered into Title XIX provider agreements with the Department of Social Services ("the Department") prior to the relevant time periods in this case.

3. The dentists provided dental services, including dentures, to Medicaid participants. All About Smiles submitted claims for reimbursement of those services to the Department.

4. Claims submitted to the Department are reviewed by MMAC staff. Cindy Lenger, an MMAC provider review analyst, noticed that All About Smiles submitted multiple claims for dentures.

5. The Department reimburses claims for dental services provided to adult Medicaid participants if they are pregnant, blind, or residents of Medicaid vendor nursing facilities. All other adults are "adults with limited benefits." The Department reimburses claims for dental services for adults with limited benefits only if they are referred by a physician and the services are required as a result of physical trauma, or to in order to not adversely affect a preexisting medical condition.

6. In March 2013, Lenger made onsite visits to several All About Smiles offices. She notified All About Smiles' general manager, Pamela Van Drie, of the Department's position on reimbursement of dental services for adults with limited benefits.

7. All About Smiles continued to submit claims on the dentists' behalf for dentures for adults with limited benefits.

8. On July 2, 2013, MMAC gave notice to the dentists that it would sanction them by requiring them to submit their claims to prepayment review.

9. Claims subject to prepayment review must be submitted in paper form with supporting documentation. A provider review analyst reviews the claims and supporting documents to determine whether the claims should be paid. The analyst then sends MMAC's determination to the administrators of the MO HealthNet electronic claims system for further processing.

10. Petitioners challenged the prepayment review sanction in the Cole County Circuit Court ("the court case"). On October 2, 2013, the court dismissed the petition as to All About Smiles for lack of standing. The court issued an order granting in part and denying in part the dentists' request for injunction. The order permits the dentists to utilize the MO HealthNet electronic claims system for all claims other than those relating to dentures. Claims relating to dentures remained subject to the prepayment review sanction.

11. On July 16, 2014, Petitioners filed notice of a motion to dismiss the court case. In their motion to dismiss before the court, they state that this Commission has jurisdiction under § 208.156.4[2] over the issue previously before the court, and "For this court to rule on the Issue of Due Process would create the possibility of inconsistent rulings on the issue."[3]

[2] Statutory references are to RSMo 2000 unless otherwise noted.
[3] It is unclear whether the motion has actually been filed with the circuit court.

12. From August 2013 until December 10, 2013, when they filed their complaint, Petitioners submitted 35 claims for dentures that MMAC denied: a total of $17,368.19 worth of claims for Dr. Dye, and a total of $16,127.02 worth of claims for Dr. Herrman.[4]

13. The following claims submitted by Petitioners lacked a physician referral:

DOS	Participant	Provider	Physician Referral?
10/17/13	A.E.	Dye	No – APRN
10/22/13	R.P.	Dye	No – RN
08/29/13	P.H.	Herrman	No – FNP
10/15/13	A.B.	Herrman	No – NP
10/15/13	M.M.	Herrman	No – APRN
10/08/13	A.I.	Herrman	No – FNP
09/24/13	T.P.	Herrman	No -- FNP
09/09/13	M.T.	Herrman	No medical referral
11/04/13	D.M.	Herrman	No medical referral
11/14/13	T.G.	Herrman	Illegible

14. The 17 claims set forth below involved participants who had a referral from a physician, and in most cases a preexisting condition was identified, but the physician did not specifically request dentures for the patient.

DOS	Participant	Provider	Physician Referral – Purpose
09/23/13	J.C.#1	Dye	"Removal of infected teeth" (D-3)[5]
10/02/13	D.M.	Dye	"Have all teeth extracted" (D-7)

[4] Van Drie testified at the hearing that some of the claims had in fact been paid. She presented no competent evidence of such payment, however, and we find that the Department's payment records contained in Exhibit B are the best evidence on this point.

[5] These page designations are from Respondent's Exhibits D and E.

09/20/13	L.Y.	Dye	"needs oral care" (D-19)
10/07/13	T.B.	Dye	"appropriate dental care" (D-23)
09/24/13	P.G.	Dye	"improvement in his dental disease" (D-27)
10/21/13	K.B.	Dye	"All caries, abscesses and infection be resolved" (D-32)
10/15/13	K.C.	Dye	"further dental care for badly decayed and missing teeth which are causing him pain" (D-37)
09/23/13	J.C. #2	Dye	"dental extractions and dental care" (D-41)
10/14/13	R.M.	Dye	"needs dental care" (D-52)
10/10/13	R.P.#1	Dye	"appropriate dental treatment" (D-56)
10/21/13	B.T.	Dye	"dental treatment" (D-64)
10/21/13	F.T.	Dye	"dental treatment" (D-69)
11/04/13	M.E.	Dye	"proper dental care" (D-72)
10/22/13	D.A.*	Herrman	"appropriate treatment" for "poor dentition" (E-8)
10/22/13	D.G.	Herrman	"extraction of hopeless teeth" (E-28)
10/23/13	D.V.	Herrman	"appropriate dental care, visits, and possible tooth extraction" (E-44)
08/29/13	J.M.	Herrman	"must be free of cavities and/or abscesses" (E-68)

*also lacks identified preexisting condition.

15. In the eight claims set forth below, the physician referral identifies a preexisting condition and states the patient's preexisting condition will be worsened without either dentures or dental care that will enable the patient to consume a better diet.

DOS	Participant	Provider	Physician Referral – Purpose
09/24/13	P.S.	Dye	Pre-diabetes; difficulty with chewing food because of poor dentition – addressing poor dentition will help her overall health. (D-11)
10/01/13	S.T.	Dye	Arthritis, GERD, osteoporosis, renal insufficiency; ability to take medications and consume nutrition rich diet may be adversely affected if dental problems not addressed. (D-15)
10/24/13	M.K.	Dye	Diabetes; able to consume but one meal a day due to discomfort of ill-fitting dentures; imperative she have several small meals a day to control diabetes; needs adjustments to dentures. (D-49)
10/08/13	C.F.	Herrman	Diabetes; without dentures cannot chew raw vegetables, nuts, lean meats and other key foods in low glycemic index diabetic and weight control diet. (E-19)
10/08/13	S.F.	Herrman	Severe dental issues and multiple medical problems; cannot eat due to lack of teeth. Has lost weight and medical problems have worsened due to this. (E-24)
11/04/13	D.H.	Herrman	Hypertension, pulmonary embolism, chronic pain. Severe dental caries causing problems with health; hast lost 16 pounds in past few months due to pain eating. Needs extraction of caries and partial dentures to regain adequate nutrition. (E-56)
11/06/13	J.W.	Herrman	Seizures and dilantin treatment / high risk of gum/dental problems. Already suffers from nutritional deficiencies; needs denture evaluation. (E-65)
09/26/13	J.R.	Herrman	Congestive heart failure and cardiomyopathy; can eat only pureed foods after all teeth extracted and has gained 30 pounds. Weight gain can cause extra stress on heart; needs dentures to be able to eat a more nutritious diet. (E-75)

16. For the eight claims listed above, Petitioners billed for the following services, and MMAC denied payment of the following amounts for the service:

Participant	Service	Amount Billed
P.S.	Upper partial, metal framework	$542.50
	Lower partial, metal framework	$542.50
S.T.	Lower partial, metal framework	$542.50
M.K.	Complete upper	$503.75
	Complete lower	$504.53
C.F.	Complete upper	$503.75
	Complete lower	$504.53
S.F.	Complete upper	$503.75
	Complete lower	$504.53
D.H.	Upper partial, metal framework	$542.50
	Lower partial, metal framework	$542.50
J.W.	Complete upper	$503.75
	Complete lower	$504.53
J.R.	Complete upper	$503.75
	Complete lower	$504.53

17. Under the MO HealthNet Dental Manual ("the Manual"), dentures and related services are reimbursed at the following maximum rates:

Complete upper	$503.75
Complete lower	$503.75
Upper partial, resin base	$377.81
Lower partial, resin base	$379.75
Upper partial, metal framework	$542.50
Lower partial, metal framework	$542.50
Denture Adjustment (upper or lower)	$28.68

18. None of the Medicaid participants at issue were blind, pregnant, children, or residents of Medicaid nursing facilities. None were referred for dentures because of trauma to the mouth, teeth, or jaw.

19. Teeth are not necessary to eat many foods.

Conclusions of Law

We have jurisdiction under §§ 208.156.2 and 621.055, both of which provide that "[a]ny person authorized under section 208.153 to provide services for which benefit payments are authorized under section 208.152" may seek review with this Commission of certain actions of the Department in regard to payments. Section 208.156.2 specifically provides the right of review to a person authorized to provide services "whose claim for reimbursement for … services is denied[.]" As the service providers seeking review, Petitioners bear the burden of proof. Section 621.055.1.

A. Petitioners' Constitutional Claims

In their trial brief, Petitioners argue that they were deprived of due process in that they were given inadequate notice before MMAC implemented its prepayment review sanction. Petitioners did not make this claim in their complaint, and MMAC argues that we should not consider it because it was untimely raised. Timely or untimely raised, we do not consider this constitutional claim because this Commission does not have authority to decide constitutional issues. *Sprint Communications Co., L.P. v. Director of Revenue*, 64 S.W.3d 832, 834 (Mo. banc 2002); *Cocktail Fortune, Inc. v. Supervisor of Liquor Control*, 994 S.W.2d 955, 957 (Mo. banc 1999). In addition, the propriety of the prepayment review sanction was previously under review in the Cole County Circuit Court. Perhaps for this reason, insufficient evidence was presented in this case for us to decide that point. Either reason is sufficient for us to conclude that we should not consider Petitioners' due process claim herein.

B. Medicaid Coverage for Dentures

Petitioners provide dental services, including dentures, to Medicaid participants. The threshold issue in this case is the extent to which dentures are a covered service under Missouri's Medicaid program. Petitioners acknowledge that under federal law, dental services are an optional service that a state may choose to provide. But once the state makes that choice, they contend, it must provide coverage sufficient to reasonably achieve its purpose and that dental services "shall, at a minimum, include relief of pain and infections, restoration of teeth and maintenance of dental health." *Pet Trial Brief at 4.* In other words, they claim that once a state has decided to provide any dental services under its Medicaid program, it must provide all dental services that fit into the above description, including dentures, to all Medicaid participants. They cite federal statutes and regulations, and argue that two Missouri cases, *McNeill-Terry v. Roling,* 142 S.W.3d 828 (Mo. App., E.D. 2004), and *Jensen v. Mo. Dep't of Health & Senior Services,* 186 S.W.3d 857 (Mo.App. W.D. 2006), support their position.

MMAC contends that dentures are covered only for select subsets of Medicaid participants – children, the blind, residents of Medicaid vendor nursing facilities, and pregnant women. In the alternative, it argues that they are available to adults with limited benefits only in circumstances involving either physical trauma or aggravation of a preexisting medical condition. MMAC relies on its own regulations and the Manual, and does not answer Petitioners' arguments about the impact of the cited cases or federal statutes and regulations on the scope of its Medicaid dental coverage.

The parties' arguments are like cross-fire aimed in different directions rather than at each other, and neither hits the mark. We must analyze them, therefore, without the parties' assistance. We conclude MMAC's alternative position – that dentures are available to adults with limited benefits under certain conditions – is correct.

Petitioners agree that dental services are an optional service the state may choose to provide. 42 U.S.C. § 1396d(a)(10). But, once the state elects to provide an optional service, it must do so in accordance with federal law, and under 42 CFR § 440.230(b), "Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose." They argue, therefore, that once a state elects to provide any dental services, it must provide "sufficient" dental services, which include dentures. Petitioners overlook the last part of the regulation, however, which provides that "The agency may place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures." 42 CFR § 440.230(d). In fact, that is what the Missouri legislature has done in § 208.152.1(21), RSMo. Supp. 2013, which provides that *"[p]rescribed medically necessary* dental services" are covered under the state's Medicaid program. (Emphasis added).

Petitioners also cite 42 U.S.C. § 1396d(r)(3)(B) to argue that dental services must "at a minimum include relief of pain and infections, restoration of teeth and maintenance of dental health." But that regulation does not purport to prescribe the scope of dental services that must be covered by a state for all Medicaid participants. Rather, the description of dental services contained therein is part of a larger paragraph within the regulation defining "early and periodic screening, diagnostic, and treatment services" for children. In short, it is completely inapposite.

Nor do the cases Petitioners cite support their position. They cite *Jensen* for the propositions that once a state elects to participate in a federal program, it must comply with all statutory and regulatory requirements imposed by law, 186 S.W.3d at 860, and that if a state elects to provide an optional Medicaid program, it must provide coverage sufficient to achieve its purpose, *id.* at 861. While these statements are true, they do not help Petitioners here because they have inaccurately characterized the underlying requirements of the Medicaid statutes and regulations.

Likewise, *McNeil-Terry* does not help Petitioners. In that case, the court of appeals held that the Division of Medical Services (MO HealthNet's predecessor) could not suspend or terminate dental benefits for Medicaid participants. In response to reduced appropriations, the Division in 2002 promulgated an emergency rule that drastically curtailed covered dental services for adults. But § 208.152.1(7) , RSMo 2000, provided that benefit payments for adult dental services "shall be made on behalf of those eligible needy persons who are unable to provide for [them] in whole or in part." As the court phrased the issue, "the Division's actions in suspending or terminating the State of Missouri's Medicaid adult dental services program, by emergency rule or other non-statutory means, violated [section 208.152.1(7).]" 142 S.W.3d at 836. Since then, the statutory law has changed. The general assembly amended § 208.152.1 in 2005 and 2007 so that Missouri's Medicaid program now covers only "medically necessary" dental benefits for most adult Medicaid participants.

MMAC argues that dentures are never a covered service for adults with limited benefits. It cites to § 19 of the Manual, as incorporated by reference into 13 CSR 70-35.010.[6] Section 19.1.G of the Manual contains the procedure codes related to denture services. Under each code related to dentures, the following language appears:

> *Coverable for children under 21 or for persons under a category of assistance for pregnant women, the blind or vendor nursing facility residents.[7]

MMAC argues that this sets forth the Department's legally binding interpretation that individuals that do not fall into a covered subset as identified above are not eligible for dentures.

The phrase cited by MMAC does not clearly limit denture coverage to Medicaid participants in the identified subsets. It states that dentures are coverable for those participants,

[6] All references to "CSR" are to the Missouri Code of State Regulations, as current with amendments included in the Missouri Register through the most recent update.

[7] Resp. ex. C at 17-20.

but it does not state they are not coverable for other participants. We look for further guidance to the Department's regulation itself, which the Department was required to promulgate under § 208.153.1, RSMo. Supp. 2013, to "define the reasonable costs, manner, extent, quantity, quality, charges and fees of MO HealthNet benefits" authorized under § 208.152. Regulation 13 CSR 70-35.010 now provides in pertinent part:

> (3)(A) MO HealthNet reimbursement of dental services shall be limited to MO HealthNet eligible children or persons receiving MO HealthNet under a category of assistance for pregnant women or the blind.
>
> (B) MO HealthNet participants living in a nursing facility will not experience dental service reductions. . . .
>
> (C) For all other eligibility categories of MO HealthNet assistance dental services will only be reimbursed if the dental care is related to trauma of the mouth, jaw, teeth, or other contiguous sites as a result of injury or as related to a medical condition when a written referral from the participant's physician states the absence of dental treatment would adversely affect the stated pre-existing medical condition.

Pursuant to the regulation, we agree with MMAC that dental services are generally covered for Medicaid participants who are children, pregnant women, blind people, or participants living in vendor nursing facilities. Dental services are a covered service for all other adults only as provided in 13 CSR 70-35.010(3)(C). But nothing in either the regulation or § 19 of the Manual[8] operates as an absolute bar to coverage of dentures for adults with limited benefits.

None of the participants for whom the claims at issue in this case were submitted are children, blind, pregnant, or in nursing facilities. They are adults with limited benefits. Whether they are eligible for denture coverage under Missouri's Medicaid program is determined by the requirements of 13 CSR 70-35.010(3)(C).

[8] Elsewhere in the record, both parties allude to other portions of the Manual, but they were not made a part of the record in this case, and it is not clear to what extent such other portions of the Manual were incorporated by reference into the Department's rule. The Department may define the requirements for Medicaid reimbursement only by published rule. *NME Hospitals v. Department of Soc. Servs.*, 850 S.W.2d 71, 74 (Mo. banc 1993).

Petitioners' Other Arguments

Van Drie testified, over MMAC's hearsay objection, that participants who came to them for dentures were told by Department case workers that they were eligible for dentures, and that case workers brought participants to their office and told their staff that the participants had dental benefits. Although Petitioners do not expressly make an estoppel argument based on this testimony, we consider it as such.

To prove estoppel against a government agency, a party must show:

> 1) a statement or act by the government entity inconsistent with the subsequent government act; 2) the citizen relied on the act; and 3) injury to the citizen. In addition, the governmental conduct complained of must amount to affirmative misconduct.

Twelve Oaks Motor Inn, Inc. v. Strahan, 110 S.W.3d 404, 408 (Mo. App. S.D., 2003). Even if we were to disregard any questions regarding the competency of the evidence on this point, Van Drie's testimony is simply too vague and general to satisfy the elements set forth in *Twelve Oaks.*

Van Drie also testified that the participants' "plan codes" as shown in Mo HealthNet's electronic system accessible to providers showed they had "active coverage" or "adjunctive dental services." Tr. 107. If her staff were unsure whether treatment was covered for a patient, they would do a "mock billing" to see if it was, then void the billing if it was not. Petitioners presented no competent documentary evidence to support this testimony, however, and we again find that it is too vague and general to help their case.

The Denied Claims

None of the claims at issue involved trauma to the patient. We analyze them, therefore, to determine whether they meet the elements of the second prong of 13 CSR 70-35.010(3)(C). We break down the regulation's requirements further into five subparts:

1) There must be a written referral

2) from a physician

3) that requests dental care

4) that states a preexisting medical condition

5) that states the absence of dental care would adversely affect the preexisting condition.

Of the 35 claims at issue in this case, nine had no physician referral. One claim has a referral, but much of it is illegible, including the signature, which may be from a nurse practitioner. The referral also does not relate the need for dentures to the patient's preexisting condition (seizures). These ten claims are ineligible for reimbursement.

The 17 claims set forth in finding of fact 14 involved participants who had a referral from a physician, and in all but one a preexisting condition was identified, but the physician did not specifically request dentures for the patient. Petitioners argue that once a physician makes a referral for dental care, the dental services provider should have the discretion to decide what dental care is warranted, including dentures. But the unrebutted testimony in the record, supported by common knowledge, is that teeth are not necessary to eat many foods. Without question, they are an aid to eating. In the claims listed in finding of fact 15, the participants' physicians made referrals that specified types of food or nutritional deficiencies that would be remedied by having teeth to chew food. But we determine that those claims in which the physician did not specifically request dentures or dental care that would enable the patient to consume a better diet are ineligible for reimbursement.

In drawing our conclusion that 27 of the claims at issue are not reimbursable, it is important to remember what is at issue in this case: reimbursement to *Petitioners* for *dentures already provided* to Medicaid participants *after* Petitioners were advised by MMAC that dentures were not a covered service for adults with limited benefits. They provided dentures anyway, and there is little doubt that by doing so they improved the overall health of the

Medicaid participants who received them. But Petitioners provided the dentures and billed for them after being told they were not a covered service. The impact of our decision that many of the claims are not reimbursable properly falls on them, not the participants.

It is also important to remember that even if Petitioners' interpretation of the state and federal Medicaid regulations differed from MMAC's interpretation, in ten of the 27 cases they did not even obtain a physician's referral. In the other 17 , they have a doctor's referral for dental services, but the service requested is often vague, like "dental treatment."[9] Petitioners complain that MMAC never requested additional information to determine whether the dentures were medically necessary, but the onus for supplying that proof falls on Petitioners. If they believed the participants at issue needed dentures, nothing would have prevented them from requesting more specific information from the referring physicians.

Some of the claims at issue meet the requirements set forth in 13 CSR 70-35.010(3)(C). For the eight claims included in finding of fact 15, the physician referral identifies a preexisting condition and states the patient's preexisting condition will be worsened without either dentures or dental care that will enable the patient to consume a better diet. We determine that these claims are eligible for reimbursement as explained further below.

Reimbursement

To determine the proper reimbursement due Petitioners, we reproduce most of the table set forth in finding of fact 15, but we substitute for the "amount billed" figures the amount allowed for the service by the Manual.

[9] We do not imply that these participants should have received *no* dental treatment; clearly, in some cases, treatment such as the extraction of infected teeth was medically necessary. But there is no evidence in the record that Petitioners billed the Missouri Medicaid program for such other services.

Participant	Service	Amount Allowed
P.S.	Upper partial, metal framework	$542 .50
	Lower partial, metal framework	$542.50
S.T.	Lower partial, metal framework	$542.50
C.F.	Complete upper	$503.75
	Complete lower	$503.75
S.F.	Complete upper	$503.75
	Complete lower	$503.75
D.H.	Upper partial, metal framework	$542.50
	Lower partial, metal framework	$542.50
J.W.	Complete upper	$503.75
	Complete lower	$503.75
J.R.	Complete upper	$503.75
	Complete lower	$503.75
TOTAL		$6,742.50

To the above total we add $57.36, the allowable amount for adjustments to upper and lower dentures for participant M.K, whose doctor referred her for "adjustments" rather than entirely new dentures, as were provided and billed for by Dr. Dye.

$6,742.50 + $57.36 = $6,799.86.

We determine that Petitioners are eligible for reimbursement of $6,799.86 for dentures and denture adjustments they provided to adult Medicaid participants with limited benefits.

Summary

Petitioners are entitled to partial reimbursement in the amount of $6,799.86 for denied claims for dentures provided to Medicaid participants.

SO ORDERED on July 18, 2014.

\s\ Karen A. Winn
KAREN A. WINN
Commissioner